

Mail or fax to:
Howalt-McDowell Insurance, Inc.
P.O. Box 986
Sioux Falls, SD 57101-0986
Fax: 605-339-3620

VEHICLE ACCIDENT CLAIM FORM



NAME OF INSURED: _____

DATE AND TIME OF ACCIDENT: _____

LOCATION OF ACCIDENT (STREET): _____

(CITY): _____ **(STATE):** _____

YOUR DRIVERS NAME: _____

YOUR VEHICLE (YEAR, MAKE, MODEL, VIN): _____

DAMAGE TO YOUR VEHICLE: _____

LOCATION OF DAMAGED VEHICLE: _____

DESCRIPTION OF ACCIDENT: _____

VIOLATION/CITATION GIVEN & TO WHOM: _____

POLICE DEPARTMENT RESPONDING: _____ **(CASE #):** _____

OWNERS NAME: _____

OWNERS ADDRESS: _____

OWNERS PHONE #: _____

DRIVER (IF DIFFERENT FROM OWNER): _____

DRIVERS ADDRESS: _____

DRIVERS PHONE #: _____

DESCRIPTION OF OTHER PARTY'S VEHICLE: _____

DAMAGE TO OTHER PARTY'S VEHICLE: _____

LOCATION OF DAMAGED VEHICLE: _____

INJURIES: _____

WITNESS: _____ **(PHONE #):** _____

ADDRESS: _____

PERSON REPORTING ACCIDENT: _____ **(PHONE #):** _____

CONTACT PERSON: _____ **(PHONE #):** _____